STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445157	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE AND HUGHES HLTH CNTR	200 STRAHL STREET FRANKLIN, TN 37064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigations #39308, #39320, and #39486, were completed on 8/22/16 to 9/6/16, at Claiborne and Hughes Health Center deficiencies were cited for #39308 in relation to the complaints under 42 CFR PART 483, Requirements for Long Term Care Facilities. Complaints #39320 and #39486 were not substantiated and deficiencies were cited unrelated to complaint.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to maintain the dignity for 2 Resident's (#6 and 7) of 9 residents reviewed. The findings included: Medical record review revealed Resident #6 was admitted to the facility on 4/10/15 with diagnoses including Bipolar I Disorder, Senile and Pre-senile Organic Psychotic Condition, Arteriosclerotic Dementia, Chronic Organic Psychotic Condition, Drug-induced Psychotic Disorder with Hallucination, Vascular Dementia, and Mental Disorder. Medical record review of the Quarterly Minimum Data Set dated 7/12/16 revealed Resident #6 was	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in the full recognition of his or her individuality. Corrective Action 1. On 8/22/16 wet soiled linen was removed from resident #6 room, pajama bottoms sent to laundry, bed made with clean sheets. Housekeeping thoroughly cleaned room to remove urine odor. Soiled sheets and incontinence pad were removed immediately. Bed was made with clean sheets. Housekeeping addressed strong urine odor with a thorough cleaning of resident #7 room which also removed the strong urine odor from the hallway.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-5-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 able to make self understood and understood others, was moderately cognitively impaired per the Brief Interview for Mental Status of 12 out of 15, no delirium, no change in mental status from baseline, no exhibition of moods, no psychosis demonstrated, no behaviors exhibited, required supervision with set-up assistance for transfers and toileting, and was always continent of bowel and bladder. Observation on 8/22/16 at 9:23 AM, in the hallway outside Resident #6's room revealed a very strong urine odor. Further observation revealed upon entering the room, the room was very warm, the heater was on and the heater fan was set to high. Further observation revealed Resident #6 seated on the side of the bed closest to the heater unit, the bed had no sheets, and he was facing the activated heater unit. Further observation revealed pajama bottoms, with a wet crotch area, secured to the heater unit blowing upward toward Resident #6 seated on the side of the bed. Further observation revealed wet soiled sheets on the floor against the wall at the foot of the bed. Interview with Resident #6 on 8/22/16 at 9:25 AM, in the resident's room, revealed when asked why the pajama bottoms were blowing in the air with the heater on stated "...I have weak kidneys and had an accident so I'm drying them..." Interview with the Director of Nursing on 8/22/16 at 9:35 AM, in Resident #6's room confirmed the room smelled strongly of urine and wet soiled pajama bottoms were blowing upward from the heater fan set on high toward Resident #6 seated on the side of the bed closest to the heater unit. Further interview confirmed the facility failed to	F 241	2. On 8/22/16 a walking round audit of each resident's room was completed by DON and the Housekeeping Supervisor to ensure each residents dignity is maintained as evidenced by no further odors being noted, beds made with clean linen and soiled linen disposed of properly. Corrections were made as needed. 3. On 10/3/16 an all staff in-service was started by the Administrator regarding dignity and respect of all residents in relation to	

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F 241	Continued From page 2 maintain the dignity of the resident. Medical record review for Resident #7 revealed admission to the facility on 11/15/95 with diagnosis including Blindness Both Eyes and Deaf-Non-speaking. Medical record review of the Quarterly Minimum Data Set dated 7/26/16 revealed Resident #7 had absence of useful hearing, absence of speech, no vision, required extensive assistance for transfers and toileting, and was always incontinent of bowel and bladder. Observation on 8/22/16 at 9:20 AM, in the hallway outside Resident #7's room revealed a very strong urine odor. Further observation upon entering Resident #7's room, revealed Resident #7 seated in a chair with 75% (percent) consumed breakfast plate on the over-bed table in front of his chair. Further observation revealed in front of the over-bed table with the breakfast tray, was the resident's bed with wet saturated sheets and a wet and brown streaked incontinence pad with a very strong odor of urine. Interview with the Director of Nursing on 8/22/16 at 9:30 AM, in Resident #7's room confirmed the urine odor was present, the bed sheets were soiled and wet while Resident #7's breakfast meal was consumed in the room. Continued interview confirmed Resident #7's dignity was not maintained.	F 241	properly disposing of soiled linen, odors on halls and resident rooms, appropriately making residents bed with clean linen and residents eating meals in an environment that is free of odors and soiled linens. 4. Unit Managers, DON and Administrator will conduct environmental rounds daily to ensure the environment is free of odors, appropriate making of residents bed with clean linen and proper disposal of soiled linens is maintained. Through these walking rounds all residents will be checked to ensure their dignity and respect is maintained. Concerns will be corrected immediately. Findings and any issues noted on the grievance log will be reported daily to the daily QA meeting and reviewed monthly at the PI/QA meeting.	10/20/16
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.	

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F 253	Continued From page 3 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility housekeeping services failed to maintain 1 Resident's room (#6) in a sanitary manner of 32 occupied rooms on the first floor. The findings included: Medical record review revealed Resident #6 was admitted to the facility on 4/10/15 with diagnoses including Bipolar I Disorder, Senile and Pre-senile Organic Psychotic Condition, Arteriosclerotic Dementia, Chronic Organic Psychotic Condition, Drug-Induced Psychotic Disorder with Hallucination, Vascular Dementia, and Mental Disorder. Observation on 8/22/16 at 9:23 AM, in the hallway outside the room of Resident #6 revealed a very strong urine odor. Further observation revealed the floor between the bed and the heater unit was sticky when walked on and black debris was present. Interview with the Director of Nursing on 8/22/16 at 9:35 AM, in Resident #6's room, confirmed the room smelled strongly of urine, the floor was sticky and the DON notified housekeeping.	F 253	Corrective Action 1. On 8/22/16 Housekeeping immediately conducted a through cleaning of resident #6 room, removed the strong urine odor and removed the black sticky debris on floor 2. On 8/22/16 a walking round audit of each resident's room was completed by DON and Housekeeping Supervisor to ensure a sanitary, orderly and comfortable interior. Any other concerns were addressed and corrected immediately. 3. On 10/3/16 an in-service for all staff was started by the Administrator regarding the importance of maintaining sanitary conditions and keeping the facility free of odors. 4. Housekeeping Supervisor and Administrator will conduct environmental rounds daily to ensure absence of odors and cleanliness of facility is maintained. Concerns will be corrected immediately. Findings will be reported to the daily QA meeting and reviewed monthly at the PI/QA meeting.	10/20/16
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

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F 282	Continued From page 4 care. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, interview, and pharmacy data review, the facility failed to follow the care plan to administer the tube feeding and flushes as ordered for 1 Resident (#1) of 9 residents reviewed. The findings included: Review of facility policy, Tube Feeding-Hydration, undated revealed "...Purpose: To provide proper hydration, via a feeding tube...Standard: Physician orders for tube feedings should include the amount of water to be given each day...Process: Record the cc's [cubic centimeters]...The amount of water given at each ordered flush, along with the total amount given each day is documented..." Review of the undated facility policy entitled "Intake and Output Measurement of Fluids" revealed "...Purpose: To provide an accurate record of the resident's intake and output...Process: Fluids from...tube feedings is calculated and recorded by the licensed nurse..." Medical record review revealed Resident #1 was admitted to the facility pn 3/4/16, and readmitted on 8/16/16 with diagnoses including Quadriplegia, Bilateral Lower Extremity Deep Vein Thrombosis and Embolism, Gastrostomy, Disease of Esophagus, Chronic Pain, Obesity, Anxiety, Depression, Seizures, and Pressure Ulcer.	F 282	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action 1. On 8/22/16 the order for automatic flush was changed to gravity flush per MD order for resident #1. The facility reviewed Diet Flow Sheet form and there were no negative outcomes from failure to document on 8/16/16, 8/17/16, and 8/19/16 for resident #1. On 8/18/16, 8/20/16, and 8/21/16 there were no negative outcome due to one formulary and one flush being documented on for resident #1.	

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F 282	Continued From page 5 Medical record review of the care plan with the original date of 3/12/16 and updated 6/14/16 "...Resident is on tube feeding..." revealed "...and Flushes as ordered..." Medical record review of the Physician Orders dated 8/1/16 to 8/31/16 revealed the tube feeding formula was Isosource 1.5 calorie concentrate at 70 cc for 22 hours, Water Flush Auto per pump at 52 cc per hour for 22 hours, and water 30 ml before and after each medication pass. Observation on 8/22/16 at 12:18 PM revealed Resident #1 in bed in his room, a tube feeding formula, Isosource 1.5 Calorie, was in a bag on a pole with 600 milliliters (ml) in the bag and the pump was set at 70 cc (cubic centimeters) per hour. Further observation revealed no water flush bag was hung on the pole. Interview with Licensed Practyical Nurse (LPN) #4 on 8/22/16 at 12:22 PM at the 1 West nursing station revealed when asked if the LPN had provided water flushes stated "...I have provided water with medications..." When asked if the LPN had done any other water flushes the LPN checked the physician orders and stated "... we don't have auto flush bags for awhile now..." When asked what awhile meant the LPN stated "...months at least..." Further interview with LPN #4 at 12:58 PM at the 1 West nursing station when asked if any water flushes were administered stated "...No, we don't have auto flush..." When asked how he was calculating or accounting for what the resident needed for the flush stated "...I have a problem..." Medical record review of the 8/2016 Diet Flow Sheet form beginning from the readmission on	F 282	2. On 8/22/16 an audit was completed by the DON for all tube feeding residents to ensure an order for gravity flush is in place. All tube feeding residents plan of care was audited and updated to reflect gravity flush. An audit on the diet flow sheet form was conducted for all tube feeding residents by the unit managers, findings were presented at the QA meeting. 3. All licensed nurses were in-serviced on 8/22/16 regarding following MD order and documentation of flushes on the Diet Flow Sheet in the Tube feeding section for nurses. An in-service was also started for all licensed nurses regarding following the plan of care. 4. An audit will be conducted on all residents with tube feeding and any new admission residents with tube feeding to ensure that orders reflect water flushes via gravity. The Diet Flow Sheet form will be audited daily by the unit managers to ensure compliance findings will be reviewed by the PI/QA meeting monthly	10/20/16

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F 282	Continued From page 6 8/16/16 revealed no documentation on 8/16/16, 8/17/16, and 8/19/16; and on 8/18/16, 8/20/16 and 8/21/16 one formulary and one flush was documented. Interview with LPN #5, on 8/22/16 at 5:12 PM at the 1 West nursing station after reviewing the 8/2016 Diet Flow Sheet form confirmed the facility failed to fill out the form completely. Interview with the Director of Nursing (DON), on 8/24/16 at 8:25 AM, in the Business Office Manager (BOM) office, confirmed the facility failed to follow the facility policy to document the intake of the fluids every shift and failed to follow the physician order and care plan to provide tube feeding and flush as ordered.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT Is not met as evidenced by: Based on facility policy review, medical record review, observation, interview, and pharmacy data review, the facility failed to follow the physician order to administer the tube feeding and flushes as ordered for 1 Resident (#1); and failed to follow physician orders for medication for 1 Resident (#2) of 9 residents reviewed.	F 309	F309 Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	

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F 309	Continued From page 7 The findings included: Review of facility policy, Tube Feeding-Hydration, undated revealed "...Purpose: To provide proper hydration, via a feeding tube...Standard: Physician orders for tube feedings should include the amount of water to be given each day...Process: Record the cc's [cubic centimeters]...The amount of water given at each ordered flush, along with the total amount given each day is documented..." Review of facility policy, Intake and Output Measurement of Fluids, undated revealed "...Purpose: To provide an accurate record of the resident's intake and output...Process: Fluids from...tube feedings is calculated and recorded by the licensed nurse..." Medical record review revealed Resident #1 was admitted on 3/4/16, facility discharge on 8/2/16 with readmission to the facility on 8/16/16 with diagnoses including Quadriplegia, Bilateral Lower Extremity Deep Vein Thrombosis and Embolism, Gastrostomy, Disease of Esophagus, Chronic Pain, Obesity, Anxiety, Depression, Seizures, and Pressure Ulcer. Medical record review of the Physician Orders dated 8/1/16 to 8/31/16 revealed the tube feeding formula was Isosource 1.5 calorie concentrate at 70 cc for 22 hours, Water Flush Auto per pump at 52 cc per hour for 22 hours, and water 30 ml before and after each medication pass. Observation on 8/22/16 at 12:18 PM revealed Resident #1 in bed in his room, a tube feeding formula, Isosource 1.5 Calorie, was in a bag on a	F 309	Corrective Action 1.a On 8/22/16 the order for automatic flush was changed to gravity flush per MD order for resident #1. The facility reviewed Diet Flow Sheet form and there were no negative outcomes from failure to document on 8/16/16, 8/17/16, and 8/19/16. On 8/18/16, 8/20/16, and 8/21/16 there were no negative outcome due to one formulary and one flush being documented on. b. On 8/22/16 resident #2 received medication as ordered. 2.a. On 8/22/16 an audit was completed by the DON for all tube feeding residents to ensure an order for gravity flush is in place. There were no other residents affected by not having the automatic flush in place An audit of the diet flow sheet form was conducted for all residents by the unit managers to ensure completeness in regards to documentations. There were no other residents affected due to not having complete documentation of the diet flow sheet form. findings will be presented at the QA meeting.	

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F 309	Continued From page 8 pole with 600 milliliters (ml) in the bag and the pump was set at 70 cc (cubic centimeters) per hour. Further observation revealed no water flush bag was hung on the pole. Interview with Licensed Practical Nurse (LPN) #4 on 8/22/16 at 12:22 PM at the 1 West nursing station revealed when asked if the LPN had provided water flushes stated "...I have provided water with medications..." When asked if the LPN had done any other water flushes the LPN checked the physician orders and stated "... we don't have auto flush bags for awhile now..." When asked what awhile meant the LPN stated "...months at least..." Further interview with LPN #4 at 12:58 PM at the 1 West nursing station when asked if any water flushes were administered stated "...No, we don't have auto flush..." When asked how he was calculating or accounting for what the resident needed for the flush LPN #4 stated "...I have a problem..." LPN #4 confirmed they had not administered 52 ml per hour flush as ordered. Medical record review of the 8/2016 Diet Flow Sheet form, where they document tube feeding and flush ml every shift, beginning from the readmission on 8/16/16 revealed no documentation on 8/16/16, 8/17/16, and 8/19/16; and on 8/18/16, 8/20/16 and 8/21/16 one formulary and one flush was documented. Interview with LPN #5, on 8/22/16 at 5:12 PM at the 1 West nursing station, after reviewing the 8/2016 Diet Flow Sheet form confirmed the facility failed to fill out the form completely. Interview with the Director of Nursing (DON) on 8/24/16 at 8:25 AM, in the Business Office	F 309	b. An audit was completed by the Unit manager on 9/27/16 to ensure all physicians orders were initiated timely for all residents. Any negative findings were corrected immediately. Findings will be presented at QA/PI meeting 3.a. All licensed nurses were in-serviced by the DON and Unit Managers on 8/22/16 regarding following MD order and documentation of flushes. An in-services was started on 10/5/16 by the DON with all licensed nurses regarding notifying MD to obtain a new order to match the facility protocol for tube feeding water flush by gravity. The protocol is to use the gravity method instead of using the auto flush method. b. An in-service was conducted by unit manager and DON regarding following MD orders and initiating medication timely per MD order as evidence by Licensed nurse obtaining a telephone	

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F 309	Continued From page 9 Manager (BOM) office confirmed the facility failed to follow the facility policy to document the intake of the fluids every shift and failed to follow the physician order to provide tube feeding and flush as ordered. Medical record review revealed Resident #2 was admitted to the facility on 6/24/16 with diagnoses including Chronic Kidney Disease Stage 3, Coronary Artery Disease, Diabetes Mellitus, Psychosis, and Dementia. Observation on 8/22/16 at 9:05 AM revealed Resident #2 in her room with a patch visible on her chest and "8/22" written on the patch. Medical record review of the Physician's telephone order dated 7/30/16 revealed "...Nitro patch [patch with Nitroglycerin for cardiac condition] 0.2 mg [milligrams]/hr [per hour] 1 daily on in AM..." Medical record review of the 8/2016 Medication Administration Record revealed "...Rx [prescription] date of 8/2/16 for Nitroglycerin Transdermal 0.2 MG/HR [milligrams per hour] patch 24 HR..." Further review revealed the patch was initially administered on 8/4/16. Review of the pharmacy data revealed on 8/2/16 the pharmacy received the telephone order dated 7/30/16 and sent the order to the back-up pharmacy. Further review revealed the back-up pharmacy delivery ticket for the nitroglycerin patch was delivered to and received by the facility on 8/2/16. Interview with LPN #3 on 8/24/16 beginning at 8:55 AM, in the BOM office revealed she wrote	F 309	order, follow the authorized telephone order, and obtain a physicians signature for the telephone order 4.a. An audit will be conducted by the Unit Managers on all residents with tube feeding and any new admission residents with tube feeding to ensure that orders reflect water flushes via gravity. The Diet Flow Sheet form will be audited weekly by the unit managers to ensure completeness findings will be reviewed by the PI/QA meeting monthly b. Chart checks for any new orders will conduct daily by pm charge nurse and double checked by the Unit Managers daily to ensure immediate initiation of MD orders is completed. This will be done for 6 weeks daily and then be maintained weekly. Findings will be 5reviewed by the PI/QA meeting.	10/20/16

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F 309	Continued From page 10 the telephone order dated 7/30/16. Further interview revealed the nurse misdated the phone order and it was really written on 8/2/16. Further interview confirmed the facility failed to follow the physician order by failing to administer the medication upon receipt by the facility on 8/2/16.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to label the tube feeding formulary bag, and failed to document the amount of formula and flush administered for 1 Resident (#1) of 9	F 322	F322 Based on the comprehensive assessment of a resident. The facility will ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible normal eating skills.	

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F 322	Continued From page 11 residents reviewed. The findings included: Review of facility policy Tube Feeding-Hydration, undated revealed "...Purpose: To provide proper hydration, via a feeding tube...Standard: Physician orders for tube feedings should include the amount of water to be given each day...Process: Record the cc's [cubic centimeters]...The amount of water given at each ordered flush, along with the total amount given each day is documented..." Review of facility policy Intake and Output Measurement of Fluids, undated revealed "...Purpose: To provide an accurate record of the resident's intake and output...Process: Fluids from...tube feedings is calculated and recorded by the licensed nurse..." Medical record review revealed Resident #1 was admitted on 3/4/16 and readmitted on 8/16/16 with diagnoses including Quadriplegia, Bilateral Lower Extremity Deep Vein Thrombosis and Embolism, Gastrostomy, Disease of Esophagus, Chronic pain, Obesity, Anxiety, Depression, Seizures, and Pressure Ulcer. Medical record review of the Physician Orders dated 8/1/16 to 8/31/16, with Licensed Practical Nurse (LPN) #4, at the nursing station on 8/22/16 at 12:23 PM, revealed the tube feeding formula was Isosource 1.5 calorie concentrate at 70 cc for 22 hours, Water Flush Auto per pump at 52 cc per hour for 22 hours, and water 30 ml before and after each medication pass. Observation on 8/22/16 at 12:18 PM, revealed	F 322	Corrective Action 1. On 8/22/16 the DON immediately labeled the tube feeding formulary bag with the time the formulary was started for resident #1. The tube feeding bag was already labeled with resident's #1 name, date started and the rate to be administered. The amount of formula administered and flushes were documented on the Diet Flow Sheet. The facility reviewed Diet Flow Sheet form and there were no negative outcomes from failure to document on 8/16/16, 8/17/16, and 8/19/16. On 8/18/16, 8/20/16, and 8/21/16 there were no negative outcome due to one formulary and one flush being documented on. On 8/23/16, the DON immediately documented the rate of administration on the label.	

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F 322	Continued From page 12 Resident #1 in bed in his room, with 600 ml's of tube feeding formula in a bag hanging on a pole. Further review revealed the formula bag label did not indicate the time of starting the feeding, the formula ordered, the rate it should be set to be administered or the initials of the nurse. Further observation revealed no water flush bag was on the pole. Tube feeding formula at 70 cc for 22 hours would provide 1540 cc per day and the water flush at 52 cc for 22 hours would provide 1144 cc per day. The medication flush would vary depending on the number of medications administered. Interview with LPN #4 on 8/22/16 at 12:22 PM, at the 1 West nursing station revealed when asked if water flushes had been provided LPN #4 stated "...I have provided water with medications..." When asked if the LPN had done any other water flushes the LPN checked the physician orders and stated "... we don't have auto flush bags for awhile now..." When asked what awhile meant the LPN stated "...months at least..." Further interview with LPN #4 at 12:58 PM at the 1 West nursing station when asked if any water flushes were administered LPN #4 stated "...No, we don't have auto flush..." When asked how he was calculating or accounting for what the resident needed for the flush LPN #4 stated "...I have a problem..." Medical record review of the 8/2016 Diet Flow Sheet form from the readmission on 8/16/16 revealed no documentation on 8/16/16, 8/17/16, and 8/19/16; and on 8/18/16, 8/20/16 and 8/21/16 one formulary and one flush was documented. Interview with the Director of Nursing (DON) on	F 322	2. On 8/22/16 an audit was conducted by the DON for all tube feeding residents to ensure that all formula bags are labeled with Date, time started, rate of flow, patients name and nurses initials, and what is being infused. An audit of the diet flow sheet form was conducted for all tube feeding residents by the unit managers to ensure completetion, findings were presented at the QA meeting. 3. An in-service was conducted by the DON on 8/22/16 for all licensed nurses regarding proper labeling of tube feeding, tube feeding documentation and water intake on the diet flow sheet for tube feeding patients. 4 Labels for tube feeding residents will be audited daily by the Unit Managers to ensure complete labeling. The Diet Flow Sheet form will be audited daily x 4 weeks and then weekly by the unit managers to ensure compliance, findings will be reviewed by the PI/QA meeting monthly	10/20/16

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F 322	Continued From page 13 8/22/16 at 3:15 PM, in the Business Office Manager (BOM) office, revealed when asked what the DON expected nursing staff to write on the tube feeding formulary bag when it was hung and administered stated "..I expect label to have the name of the resident, date and time it was started and the rate to be administered..." Interview with LPN #5 on 8/22/16 at 5:12 PM, at the 1 West nursing station, after reviewing the 8/2016 Diet Flow Sheet form confirmed the facility failed to fill out the form completely. Observation on 8/23/16 at 8:15 AM, revealed Resident #1 in bed and the tube feeding formula bag with the label including the resident's name, date, start time, and initials. Further review revealed no rate of administration was documented on the label. Interview with the DON on 8/23/16 at 10:00 AM, in the BOM office confirmed the DON had checked the tube feeding formulary bag and the label did have some information "...but was missing the rate..." Interview with the DON on 8/24/16 at 11:00 AM, in the BOM office confirmed the facility failed to document on the diet flow sheet for tube feeding and fluids. Interview with the DON on 8/24/16 at 8:25 AM, in the BOM office confirmed the facility failed to follow the facility policy to document the intake of the fluids every shift.	F 322		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	F465 The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	

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F 465	Continued From page 14 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain 4 of 4 first floor showers of 8 total showers and 1 Resident (#1) room of 32 occupied rooms on the first floor in a safe manner. The findings included: Medical record review revealed Resident #1 was admitted on 3/4/16 abd readmitted on 8/16/16 with diagnoses including Quadriplegia, Bilateral Lower Extremity Deep Vein Thrombosis and Embolism, Gastrostomy, Disease of Esophagus, Chronic pain, Obesity, Anxiety, Depression, Seizures, and Pressure Ulcer. Observation on 8/22/16 at 8:55 AM and 12:18 PM, revealed Resident #1 in bed in his room, a tube feeding formula was being administered via a bag on a pole with 3 rusted legs. Further observation revealed the wall, to the right side of the heater/air conditioner unit was wrinkled and wet to the touch from the bottom of the window sill to the floor. Interview with the Director of Nursing on 8/22/16 at 9:43 AM, in Resident #1's room confirmed the wall was wet and wrinkled to the right of the heater/air conditioner unit. Interview with the Maintenance Director on	F 465	Corrective Action 1.a On 8/22/16 resident #1's tube feeding pole with the rusted legs was immediately replaced by the unit manager On 8/22/16 the wrinkled and wet wall to the right side of the heater/air conditioner in resident # 1 room was immediately repaired by maintenance. A roofing vendor came to inspect the roof for leakage The shower room on 1 East closest to room 125 was flushed and thoroughly cleaned by housekeeping. The dead winged insect and the wadded up glove was immediately removed from the second shower room closest to the nursing station on 1 East. The soiled linen on the floor was immediately removed and shower seat thoroughly cleaned by housekeeping in the shower room on 1 West. The urine filled commode was flushed and soiled towels removed immediately in the shower room on the left closest to the nursing station on 1 East. 2. On 8/22/16 an audit of all shower rooms were conducted by the Housekeeping supervisor to ensure that the environment was safe and sanitary.	

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F 465	Continued From page 15 8/22/16 at 11:55 AM, in the Business Office Manager office stated "...there was a roof leak and that's why the wall is wet...". Observation on 8/22/16 during the initial facility tour revealed the following: 1.) At 8:45 AM-The shower rooms on 1 East. The shower room closest to room 125 was not occupied, had feces in the commode, and a brown stain on the floor in front of the commode. The second shower room closest to the nursing station on 1 East was not occupied, had a dead winged insect on the floor and a wadded up glove on the sink. 2.) At 8:50 AM-The shower rooms on 1 West. The shower room on the right was not occupied and had soiled linen on the floor and a brown stain on the shower seat. The shower room on the left, closest to the nursing station on 1 East, was not occupied, had urine in the commode, and soiled towels on the floor. Interview with the Director of Nursing, on 8/22/16 beginning at 9:45 AM, after observing both 1 East showers and 1 unoccupied shower on 1 West, confirmed the facility failed to maintain the environment in a safe manner.	F 465	On 10/4/16 all tube feeding poles were checked by central supply to ensure poles were free of rust or issues. All exterior walls were audited by the maintenance Director on 8/23/16 to ensure all exterior walls were intact and free from water damage. 3. On 10/3/16 An in-service was started by the DON with all staff regarding maintaining a safe clean environment in regards to proper disposal of soiled linen and trash, prompt flushing for disposal of waste, all staff's responsibility to pick up debris when noticed as well as reporting maintenance concerns to ensure safety and clean environment. 4. Housekeeping Supervisor, Maintenance Director and Administrator will conduct environmental rounds daily to ensure the safety and cleanliness of facility is maintained. Concerns will be corrected immediately. Findings will be reported to the daily QA meeting and reviewed monthly at the PI/QA meeting.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record	F 502		10/20/16

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F 502	Continued From page 16 review, interview, and pharmacy data review, the facility failed to follow physician orders for laboratory tests for 1 Resident (#4) of 9 residents reviewed. The findings included: Medical record review revealed Resident #4 was admitted on 3/17/15, and readmitted on 7/28/16 with diagnoses including Schizophrenia, Dementia, Anxiety, Disturbance of Conduct, and Seizure Disorder. Medical record review of the Consultant Pharmacist Recommendation to Physician form dated 10/19/15 revealed "...resident is currently taking Divalproex Sprinkles 125 mg 8 capsules at bedtime. The usual monitored tests are Valproic Acid...Please consider ordering baseline labs and repeat every six months..." Further review revealed the hand written notation "...CMP [Comprehensive Metabolic Panal] + [and] Depakote level q [every] 6 months..." Medical record review of the laboratory data revealed no laboratory results for a CMP and Depakote level in 10/2015. Interview with the DON on 8/25/16 at 12:25 PM, in the BOM office confirmed the facility failed to write the phone order for the 10/19/15 accepted pharmacy recommendation for lab work and failed to obtain the lab work. Interview with Resident #4's Physician on 8/25/16 at 3:00 PM, in the second floor dayroom confirmed the writing on the 10/19/15 pharmacy recommendation was his and his expectation was for the facility staff to write a telephone order and	F 502	F502 The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Corrective Action 1. On 8/25/15, the DON immediately obtained an order for the lab work for resident #4. 2. On 10/3/16 an audit was started for all residents receiving labs requested per pharmacy recommendation to ensure that current labs were being obtained per MD order. 3. On 8/25/16 an in-service was conducted by the DON for all licensed nurses regarding processing pharmacy recommendations. Procedure: The DON will receive the pharmacy recommendation. The Unit Managers will notify the MD regarding the recommendations. The MD will accept or decline the recommendation of pharmacy. If there are no changes nursing will document no changes noted and file. If changes- then nursing will transcribe the order and process accordingly file in chart	

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F 502	Continued From page 17 "...do what was ordered..."	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain accurate and complete medical records for 3 Residents (#2, 4, and 8) of 9 records reviewed. The findings included: Medical record review revealed Resident #2 was admitted to the facility on 6/24/16 with diagnoses including Chronic Kidney Disease Stage 3, Coronary Artery Disease, Diabetes Mellitus, Psychosis, and Dementia. Medical record review revealed Resident #2's Brief Interview for Mental Status (BIMS) scored 14/15, which revealed the resident was cognitively intact.	F 514	4. Residents with labs requested per pharmacy recommendation will be monitored by the Unit Managers monthly through crosschecking the original recommendations by the orders received from the MD. Any recommendations unresolved will be submitted to the Medical Director for resolution. Findings will be reviewed monthly at the PI/QA meeting F514 The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; a record of the resident's assessments, the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Corrective Action 1. The facility reviewed shower/bath documentation for resident #2, there were no negative outcomes due to no documentation. Interview with resident #2 shows showers were offered and declined at times.	

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F 514	Continued From page 18 Observation on 8/22/16 at 9:05 AM and 12:28 PM, and on 8/23/16 at 8:18 AM revealed Resident #2 was wearing clean clothing, no personal odors were noted, was ambulatory, and was feeding herself her meal at bedside. Interview with Resident #2 on 8/22/16 at 12:28 PM in the Resident's room when asked if the facility offered the resident showers or baths stated "...Yes..." Medical record review revealed no documentation of showers/baths provided to Resident #2. Interview with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #2, on 8/23/16 beginning at 4:18 PM, in the Business Office Manager (BOM) office confirmed the facility failed to maintain documentation of showers provided, therefore the medical record was not complete. Medical record review revealed Resident #4 was admitted on 3/17/15 and readmitted to the facility on 7/28/16, with diagnoses including Schizophrenia, Dementia, Anxiety, Disturbance of Conduct, and Seizure Disorder. Medical record review revealed no signed Physician Orders for January, February and March 2016. Interview with LPN #3 on 8/24/16 at 9:30 AM, in the BOM office confirmed the signed Physician Orders could not be found and the facility failed to maintain an accurate medical record. Medical record review revealed Resident #8 was admitted to the facility on 8/5/16 with diagnoses	F 514	The facility reviewed medical record for Resident #4, they were reprinted and signed by the Physician. There were no negative outcomes due to not having signed Physicians orders for January, February, and March 2016 The facility reviewed medical record for Resident # 8, there were no negative outcomes due to no documentation of the Activities of Daily Living, Bowel movement, food and fluid intake, shower/bath provided from admission on 8/5/16 through 8/18/16. Resident #8 discharged from facility on 8/18/16. The facility reviewed medical record for Resident # 8, there were no negative outcomes due to no documentation for the 4:30PM fingerstick BS BID result from 8/16/16 to 8/18/16. Resident #8 discharged from facility on 8/18/16. 2. An audit was conducted by the Unit Managers on 8/22/16 to ensure shower/bath documentation was complete for each resident. An audit was conducted by Medical records to ensure Physician Order sheets are signed and in the chart for each resident for January 2016 through present	

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F 514	Continued From page 19 including Depression, Neuromuscular Dysfunction of Bladder, Diabetes Mellitus Type 2, Obsessive-Compulsive Disorder, Conductive Hearing Loss, History of Venous Thrombosis and Embolism, Benign Prostate Hypertrophy, and Insomnia. The resident left the facility Against Medical Advice (AMA) on 8/18/16. Medical record review revealed no documentation of the Activities of Daily Living (ADL), no documentation of the number of bowel movements, no documentation of the food and fluid intake, no documentation of shower/bath provided from admission on 8/5/16 through 8/18/16. Interview with the DON on 8/25/16 at 8:10 AM, in the BOM office confirmed the facility failed to have a complete and accurate medical record. Medical record review of the 8/11/16 Physician Telephone Orders revealed "...1.) ...[various types of blood tests]...2.) Fingerstick BS [Blood Sugar] BID [2 times daily]..." Medical record review of the 8/2016 Medication Administration Record for Fingerstick BS BID revealed no documentation for the 4:30 PM result from 8/16/16 to 8/18/16. Interview with the DON on 8/25/16 at 8:10 AM, in the BOM office confirmed the facility failed to have the results of the ordered blood tests in the medical record therefore the medical record was not complete.	F 514	An audit was conducted by unit managers to ensure Activities of Daily Living, Bowel movement, food and fluid intake shower/bath are documented for each resident. An audit was completed by unit manager to ensure finger stick results were documented for all residents that have an order for fingerstick (blood sugar). 3. An in-service for all CNTs and Licensed nurses was conducted by the DON regarding complete documentation of Activities of Daily Living, Bowel movement, food and fluid intake, and shower/ bath. An in-service was conducted for all licensed nurses regarding the maintenance of the signed physicians order sheet in the medical record. An in-service was conducted by the DON for all licensed nurses regarding documentation of finger stick results. 4. The Unit managers or designee will conduct daily audits of Activities of Daily Living l documentation, Bowel Movement documentation, food and fluid intake and finger stick documentation for 4 weeks and then weekly to ensure compliance. Results will be reviewed in the monthly QA/PI meeting.	10/20/16